Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated January 1, 2015
Highlights indicated change from previous posting.

ALZHEIMER'S DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cholinesterase Inhibitors [CL]		
donepezil [CL] – except 23 mg tablet donepezil ODT [CL] EXELON transdermal (rivastigmine) [CL] rivastigmine capsule [CL]	*ARICEPT (donepezil) 23 mg tablet* [CL] *donepezil 23 mg tablet* [CL] *EXELON solution (rivastigmine)* [CL] *galantamine* [CL] *galantamine ER* [CL]	▪ Link to PA Form for Alzheimer's Agents (required for all drugs in class) ▪ Donepezil 5 and 10 mg will be approved for patients with mild to severe dementia ▪ Other cholinesterase inhibitors will be approved for patients with mild to moderate dementia ▪ Aricept 23 mg will be approved for patients who have received donepezil 10 mg/day for at least three months ▪ Non-preferred agents will be approved for patients who have failed a preferred agent within the last 6 months
NMDA Receptor Antagonist		
NAMENDA (memantine) [CL]	*NAMENDA XR (memantine)* [CL]	▪ Link to PA Form for Alzheimer's Agents (required for all drugs in class) ▪ Namenda will be approved for patients with moderate to severe dementia. ▪ Namenda XR will only be approved for patients who have tried and failed Namenda immediate release

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ANALGESICS, NARCOTIC – LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
KADIAN (morphine ER) methadone morphine ER tablets	*BUTRANS (buprenorphine transdermal)* [CL] *CONZIP (tramadol ER)* *EXALGO (hydromorphone)* *fentanyl transdermal* [CL] *morphine ER capsules (generic KADIAN, AVINZA)* *NUCYNTA ER (tapentadol ER)* *oxycodone ER* *OXYCONTIN (oxycodone ER)*[CL] *oxymorphone ER* *tramadol ER*[CL] *ZOHYDRO ER (hydrocodone ER)*	▪ Link to PA Form for Narcotic Analgesics, Long-acting (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients who have received the same non-preferred agent in the last 60 days with a day supply greater than 3 days. ▪ New prescriptions for non-preferred agents will be approved for patients meeting one of the following criteria: – Documented failure of at least a 30 day trial of a preferred agent within the previous 6 months. – Diagnosis of malignant pain (ICD- 9 = 140-208, 99.25 or chemotherapy administration related CPT code). ▪ Tramadol ER or ConZip will be approved with adequate documentation providing therapeutic justification for why generic immediate release ▪ tramadol cannot be used. ▪ Butrans will be approved for patients meeting all of the following criteria: – No history of opioid abuse or addiction. – Diagnosis of moderate or severe chronic pain (ICD-9 = 714.xx, 715.xx, 338.2, 338.4) – Inability to take any oral medications. – History of other long-acting opioid analgesics within the last 60 days at a current dose < 30 mg morphine equivalents. ▪ Fentanyl transdermal will be approved for patients meeting one of the following criteria: – Diagnosis of malignant pain (ICD- 9 = 140-208, 99.25 or chemotherapy administration related CPT code) – Inability to swallow tablets or capsules. (Documentation required). – History of 30 days or more of a preferred agent

ANALGESICS, NARCOTIC – LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		in the last 180 days and fentanyl dose requested is equivalent to the dose of preferred agent tried or documentation supporting an increase or decrease in the morphine equivalent dose provides justification. ▪ OxyContin (oxycodone ER) will be approved for patients meeting one the following criteria: – Diagnosis of malignant pain (ICD- 9 = 140-208, 99.25 or chemotherapy administration related CPT code) – History of 30 days or more of a preferred agent in the last 180 days – Oxycodone dose requested is equivalent or less than the dose of the preferred agent tried or documentation supporting an increase in the morphine equivalent dose provides justification. – Adequate documentation supporting the use over other long-acting opioids ▪ Zohydro ER will only be approved after an adequate trial of at least one preparation of **each** of the available long-acting opioids including morphine, fentanyl, oxycodone, hydromorphone and oxymorphone **plus** either documented failure of **all** of these agents and/or a documented serious adverse effect to **all** of these agents.

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ANALGESICS, NARCOTIC – SHORT-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral/Rectal/Nasal		
butorphanol tartrate nasal spray codeine (except solution) codeine/APAP hydrocodone/APAP hydromorphone tablet morphine IR tablet , solution and concentrate solution oxycodone/APAP oxycodone solution and concentrate ROXICET solution (oxycodone/APAP) tramadol IR tramadol/APAP	*butalbital/APAP/caffeine/ codeine* *butalbital compound w/codeine (butalbital/ASA/caffeine/ codeine)* *carisoprodol compound w/codeine (carisoprodol/aspirin/codeine)* *codeine solution* *dihydrocodeine/ aspirin/caffeine* *hydrocodone/ibuprofen* *hydromorphone liquid and suppositories* *IBUDONE (hydrocodone/ibuprofen)* *levorphanol* *meperidine* *morphine suppositories* *NUCYNTA (tapentadol)* *OXECTA (oxycodone)* *oxycodone IR tablets, capsules* *oxycodone/aspirin* *oxycodone/ibuprofen* *oxymorphone* *pentazocine/naloxone* *PRIMLEV (oxycodone/APAP)* *ROXICODONE (oxycodone)* *XODOL(hydrocodone/APAP)* *ZAMICET (hydrocodone/APAP)*	▪ Link to PA Form for Narcotic Analgesics, Short-acting (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of 3 preferred agents with at least a 7 day trial of each in the past 180 days
Buccal/Sublingual/Transmucosal		
	ABSTRAL (fentanyl)[CL] *fentanyl OTFC*[CL] *FENTORA (fentanyl)*[CL] *SUBSYS (fentanyl)*[CL]	▪ Link to PA Form for Fentanyl (transmucosal) (required for all buccal/sublingual/ transmucosal drugs) ▪ Fentanyl buccal/sublingual /transmucosal will only be approved for breakthrough cancer pain in patients already receiving, and tolerant to, opioid therapy.

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ANALGESICS, PAIN – OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CYMBALTA (duloxetine) [CL] duloxetine[CL] gabapentin capsules, tablets	*gabapentin solution* *GRALISE (gabapentin)* *HORIZANT (gabapentin)* *lidocaine transdermal*[CL] *LIDODERM transdermal (lidocaine)* [CL] *LYRICA (pregabalin* [CL] *SAVELLA (milnacipran)*[CL]	▪ Link to PA form for Analgesics, Topical – Lidoderm transdermal will be approved for patients with pain associated with postherpetic neuralgia ▪ Link to PA Form for Fibromyalgia Agents – Duloxetine, Lyrica and Savella will be approved for patients with a diagnosis of fibromyalgia – Dual therapy with duloxetine and Savella will not be authorized for payment ▪ For non-pain uses of duloxetine, refer to drug class criteria for Antidepressants, Other. For non-pain uses of Lyrica, gabapentin, Gralise and Horizant refer to drug class criteria for Antiepileptic Agents for Pain and Mood Disorders.

ANDROGENIC DRUGS (TOPICAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANDROGEL (testosterone) [CL] TESTIM (testosterone) [CL]	*ANDRODERM (testosterone)*[CL] *AXIRON (testosterone)* [CL] *FORTESTA (testosterone)* [CL] *testosterone (generic Testim)*	▪ Link to PA Form for Androgenic Agents (required for all drugs in the class) ▪ Preferred androgenic drugs will be approved for male patients with a documented diagnosis of hypogonadism with – At least one non-sexual dysfunction symptom – Serum testosterone level below the lower limit of normal range for testing laboratory ▪ Non-preferred agents will be approved for male patients meeting the above criteria with documented failure of a preferred agent within the last 6 months

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE Inhibitors		
benazepril captopril enalapril lisinopril ramipril	*EPANED (enalapril powder for solution)* *fosinopril* *moexipril* *perindopril* *quinapril* *trandolapril*	▪ Link to PA Form for ACE Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved if the patient has a history of one preferred agent in the last 6 months ▪ EPANED will only be approved for patients who have documented inability to swallow tablets
ACE Inhibitor / Diuretic Combinations		
benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ	*fosinopril/HCTZ* *moexipril/HCTZ* *quinapril/HCTZ*	▪ Link to PA Form for ACE Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved if the patient has a history of one preferred agent in the last 6 months
Angiotensin Receptor Blockers		
BENICAR (olmesartan) DIOVAN (valsartan) losartan	*candesartan* *EDARBI (azilsartan)* *eprosartan* *irbesartan* *MICARDIS (telmisartan)* *telmisartan* *valsartan*	▪ Link to PA Form for ARB-Angiotensin II Receptor Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved if the patient has a history of one preferred agent in the last 6 months
Angiotensin Receptor Blocker / Diuretic Combinations		
BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (valsartan/HCTZ) losartan/HCTZ	*candesartan/HCTZ* *irbesartan/HCTZ* *EDARBYCLOR (azilsartan/chlorthalidone)* *MICARDIS-HCT (telmisartan/HCTZ)* *TEVETEN-HCT (eprosartan/HCTZ)* *valsartan/HCTZ*	▪ Link to PA Form for ARB-Angiotensin II Receptor Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved if the patient has a history of one preferred agent in the last 6 months
Angiotensin Modulator / Calcium Channel Blocker Combinations		
AZOR (olmesartan/amlodipine) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) TARKA (trandolapril/verapamil) TRIBENZOR (olmesartan/amlodipine/HCTZ)	*benazepril/amlodipine* *telmisartan/amlodipine* *trandolapril/verapamil*	▪ Link to PA Form for Angiotensin Modulators-Calcium Channel Blockers (required for Non-preferred drugs) ▪ Non-preferred agents will be approved if the patient has a history of one preferred agent in the last 6 months. ▪ Individual prescriptions for benazepril and amlodipine should be used for patients requiring this combination.

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Direct Renin Inhibitors		
	TEKTURNA (aliskiren)	▪ Link to PA Form for Direct Renin Inhibitors (required for all drugs in the class) ▪ Tekturna will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB ▪ Tekturna will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients
Direct Renin Inhibitor Combinations		
	AMTURNIDE (aliskiren/amlodipine/HCTZ) *TEKAMLO (aliskiren/amlodipine)* *TEKTURNA/HCT (aliskiren/HCTZ)*	▪ Link to PA Form for Direct Renin Inhibitors (required for all drugs in the class) ▪ Aliskiren combinations will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB ▪ Aliskiren combinations will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients

ANTI-ALLERGENS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	GRASTEK (Timothy grass pollen allergen extract) *RAGWITEK (Short Ragweed pollen allergen extract)*	

ANTIBIOTICS, GI

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALINIA suspension (nitazoxanide) preferred for age <18 years only metronidazole tablet neomycin vancomycin capsules	*ALINIA tablet and suspension (nitazoxanide)* *DIFICID (fidaxomicin)* *FLAGYL/FLAGYL ER (metronidazole)* *metronidazole capsule* *tinidazole* *XIFAXAN (rifaximin)*	▪ Non-preferred agents will only be approved after documented failure of a preferred agent.

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ANTIBIOTICS, INHALED[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) CAYSTON (aztreonam)	*TOBI (tobramycin)* *TOBI Podhaler* [NR] *tobramycin solution*	▪ Link to PA Form for Inhaled Antibiotics (required for all agents in class) ▪ Preferred agents will be approved for patients with a diagnosis of Cystic Fibrosis. ▪ Non-preferred agents will only be approved after documented failure of a preferred agent

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
mupirocin ointment	*ALTABAX (retapamulin)* *gentamicin ointment and cream* *mupirocin cream*	▪ Link to PA Form for Antibiotics, Topical (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved after documented failure of a preferred agent

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN OVULES (clindamycin) METROGEL (metronidazole)	*clindamycin cream* *metronidazole* *VANDAZOLE (metronidazole)*	▪ Non-preferred agents will only be approved after documented failure of a preferred agent

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) [CL] enoxaparin syringe FRAGMIN (dalteparin) LOVENOX vial (enoxaparin) PRADAXA (dabigatran) [CL] warfarin XARELTO (rivaroxaban) [CL]	*enoxaparin vial* *fondaparinux* *INNOHEP (tinzaparin)*	▪ Link to PA Form for Non-Preferred drugs ▪ Enoxaparin, fondaparinux or Innohep will be approved after a trial and failure of a preferred agent in the last 30 days ▪ Eliquis, Xarelto and Pradaxa will be approved for non-valvular atrial fibrillation ICD-9=427.31 ▪ Eliquis will be approved for prophylaxis of DVT/PE following hip or knee replacement or for treatment of DVT or PE ▪ Pradaxa will be approved for treatment of DVT/PE for patients who have been treated with a parenteral anticoagulant or to reduce the risk of recurrence of DVT or PE for patients who have been previously treated ▪ Xarelto will be approved for DVT or PE treatment or to reduce the risk of recurrence of DVT or PE or for prophylaxis to prevent DVT in knee or hip replacement surgery

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ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Barbiturates		
phenobarbital primidone		▪ Link to PA Form for Non-Preferred drugs The non-preferred agents will be approved only after documented failure of a preferred agent.
Benzodiazepines		
clonazepam tablet DIASTAT (diazepam rectal) ONFI tablet (clobazam) CL	*clonazepam ODT* CL *diazepam rectal* *ONFI suspension (clobazam)* CL	▪ Link to PA Form for Non-Preferred drugs The non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Onfi will be approved for patients with a diagnosis of seizure disorder (ICD-9 = 345) within the previous 2 years. ▪ Link to PA Form for Clonazepam ODT Form. ▪ Clonazepam orally disintegrating tablets (ODT) will be approved for patients that have a diagnosis of panic disorder with or without agoraphobia whose clonazepam dose is being titrated up or down or who have a documented inability to swallow other oral medication dosage forms.
Hydantoins		
DILANTIN (phenytoin) DILANTIN INFATAB (phenytoin) PEGANONE (ethotoin) phenytoin phenytoin chew tab	*PHENYTEK (phenytoin)* *DILANTIN suspension (phenytoin)*	▪ Link to PA Form for Non-Preferred drugs The non-preferred agents will be approved only after documented failure of a preferred agent.
Succinimides		
CELONTIN (methsuximide) ethosuximide syrup ZARONTIN Capsules (ethosuximide)	*ethosuximide capsules*	▪ Link to PA Form for Non-Preferred drugs The non-preferred agents will be approved only after documented failure of a preferred agent.

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ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Adjuvants		
carbamazepine IR CARBATROL (carbamazepine ER) DEPAKOTE Sprinkle (divalproex) divalproex tablet divalproex ER gabapentin capsule, tablet GABITRIL (tiagabine) lamotrigine CL levetiracetam solution, tablets CL oxcarbazepine tablets CL TEGRETOL XR (carbamazepine XR) topiramate sprinkle and tablets CL TRILEPTAL Suspension (oxcarbazepine) CL valproate valproic acid VIMPAT (lacosamide) CL zonisamide CL	*APTIOM (eslicarbazepine)* CL *BANZEL (rufinamide)* CL *carbamazepine ER* *carbamazepine XR* *divalproex sprinkle* *EQUETRO (carbamazepine ER)* *felbamate* *FYCOMPA (perampanel)* CL *gabapentin solution* *LAMICTAL ODT (lamotrigine)* CL *lamotrigine XR* CL *levetiracetam ER* CL *LYRICA (pregabalin)* CL *oxcarbazepine suspension* CL *OXTELLAR XR (oxcarbazepine)* CL *POTIGA (ezogabine)* CL *SABRIL (vigabatrin)* CL *STAVZOR (valproic acid)* CL *tiagabine* *topiramate ER* *TROKENDI XR (topiramate ER)*	▪ Link to PA Form for Non-Preferred drugs ▪ Carbamazepine IR, Carbatrol, Depakote sprinkle, divalproex tablets, divalproex ER, gabapentin capsules/tablets, Tegretol XR, valproate, and valproic acid are preferred agents and will be approved for eligible participants within the approved dosage quantities and age limits. Non-preferred brand drugs will be approved for patients with a diagnosis of seizure disorder (ICD-9=345) who have been receiving the brand drug for 90 days and are compliant with therapy (72 days out of the past 90). ▪ Carbamazepine ER, carbamazepine XR, ethosuximide capsules, Equetro, felbamate, gabapentin solution, and tiagabine will be approved for patients with a documented failure of a preferred agent in the past 180 days. ▪ Levetiracetam, Vimpat and zonisamide will be approved for patients with a diagnosis of seizure disorder (ICD-9 = 345) within the previous 2 years. ▪ Levetiracetam ER, Sabril, Stavzor, Potiga and Banzel will be approved for patients with a diagnosis of seizure disorder (ICD-9 = 345) who have a documented failure of another antiepileptic agent with the past 180 days. ▪ Link to PA Form for Antiepileptic Agents for Pain and Mood Disorders for Preferred drugs with Clinical Edits (lamotrigine, lamotrigine XR, Lyrica, oxcarbazepine tablets, topiramate, Trileptal suspension ▪ Lamotrigine, oxcarbazepine tablets and Trileptal (oxcarbazepine) suspension will be approved for patients with one of the following diagnoses within previous 2 years: – Seizure disorder (ICD-9=345) – Bipolar disorder (ICD-9=296) ▪ Lamotrigine XR will be approved for patients with a diagnosis of seizure disorder (ICD-9 = 345) within the previous 2 years.

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ANTICONVULSANTS

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		▪ Lyrica will be approved for patients meeting one of the following criteria: – Seizure disorder (ICD-9=345) – Diagnosis of neuropathic pain, diabetic peripheral neuropathy (ICD-9=250.6) or postherpetic neuralgia (ICD-9=053.1) which has failed treatment with gabapentin in the last 2 years. – Fibromyalgia (ICD-9= 729.1) – Neuropathic pain associated with spinal cord injury that has persisted continuously for at least three months ▪ Topiramate will be approved for patients with one of the following diagnoses within previous 2 years: – Seizure disorder (ICD-9=345) – Migraine headache (ICD-9=346 – Extended release tompiramate preparations will only be approved for seizure disorders

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ANTIDEPRESSANTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bupropion HCl IR bupropion SR bupropion XL MARPLAN (isocarboxazid) mirtazapine tablets PARNATE (tranylcypromine) trazodone venlafaxine IR venlafaxine ER capsules	*APLENZIN (bupropion HBr)* *BRINTELLIX (vortioxetine)* *desvenlafaxine ER* *desvenlafaxine fumarate ER* *duloxetine* CL *EMSAM (selegiline transdermal)* CL *FETZIMA (levomilnacipran)* *FORFIVO XL (bupropion)* *mirtazapine ODT* *nefazodone* *OLEPTRO ER (trazodone)* *phenelzine* *PRISTIQ (desvenlafaxine succinate)* *tranylcypromine* *venlafaxine ER tablets* *VIIBRYD (vilazodone)*	▪ Link to PA Form for Antidepressants, Other (required for Non-Preferred Drugs - except duloxetine and Emsam - see below) ▪ Link to PA Form for duloxetine ▪ Duloxetine will be approved for patients meeting one of the following criteria: – Diagnosis of major depressive disorder (MDD) or generalized anxiety disorder (GAD) who have tried and failed treatment with a preferred antidepressant – Diagnosis of diabetic peripheral neuropathy (DPN) who have tried and failed gabapentin therapy in the past 6 months – Diagnosis of fibromyalgia ▪ Link to PA Form for Emsam ▪ Emsam will be approved for adult patients meeting all of the following criteria: – Diagnosis of major depressive disorder (MDD) – Failure of trials of an SSRI, an SNRI and at one least one other antidepressant from another therapeutic class – Not currently receiving any contraindicated medications – No diagnosis of pheochromocytoma

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ANTIDEPRESSANTS, SSRIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
citalopram escitalopram tablet fluoxetine capsules, solution fluvoxamine paroxetine tablet sertraline	*BRISDELLE (paroxetine)* [CL] *escitalopram solution* *fluoxetine tablets* *fluoxetine weekly* [CL] *fluvoxamine ER* *paroxetine CR* *PAXIL Suspension (paroxetine)* *PEXEVA (paroxetine)*	▪ Link to PA Form for Antidepressants, SSRIs (required for Non-Preferred drugs – including fluoxetine weekly) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months. ▪ Fluoxetine weekly will be approved for patients with a diagnosis of depression who are not receiving other medications at least daily.

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ANTIEMETIC/ANTIVERTIGO AGENTS (ORAL/TRANSDERMAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cannabinoids		
	CESAMET (nabilone) [CL] *dronabinol* [CL]	▪ Link to PA Form for Cannabinoids ▪ Dronabinol will be approved for patients who have received chemotherapy in the last 12 months or have a history of HIV associated cachexia.
5HT$_3$ Receptor Blockers[CL]		
ondansetron ondansetron ODT	*ANZEMET (dolasetron)* *granisetron* *SANCUSO (granisetron)* *ZUPLENZ (ondansetron)*	▪ Link to PA Form for Antiemetics, Oral - 5HT3 Antagonists (required for all drugs except PA is not required for Preferred agents in children 15 years and younger within the quantity limit of one tablet daily) ▪ Ondansetron and ondansetron ODT will be approved for patients with chemotherapy or radiation-induced nausea and vomiting or documented hyperemesis gravidarum. Sancuso will be approved for patients with chemotherapy or radiation-induced nausea and vomiting who cannot take oral therapy (documentation required). Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.
NK1 Receptor Antagonist		
EMEND (aprepitant)		
Other		
meclizine OTC and RX metoclopramide prochlorperazine promethazine (oral, rectal 12.5 & 25 mg) trimethobenzamide TRANSDERM-SCOP (scopolamine)	*COMPRO (prochlorperazine) rectal* *DICLEGIS (doxylamine/pyridoxine)* [CL] *METOZOLV ODT (metoclopramide)* *promethazine 50 mg suppositories*	▪ Link to Universal PA Form ▪ A prescription is required for all drugs

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ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole fluconazole griseofulvin suspension nystatin tablets and suspension	*flucytosine* *griseofulvin V tablets* CL *griseofulvin ultramicrosize tablets* CL *itraconazole* CL *ketoconazole* CL *NOXAFIL (posaconazole)* *nystatin oral powder* *ONMEL (itraconazole)* CL *terbinafine* CL *voriconazole*	▪ Ketoconazole will be approved for blastomycosis, coeideioidomycosis, histoplasmosis, charmonmycosis or parcoccidodomycosis in patients who have failed or cannot tolerate other oral antifungal agents. – Ketoconazole will not be approved for fungal infections of the skin or nails or for fungal meningitis. – Ketoconazole will not be approved for patients with liver disease, adrenal problems, or those who have undergone recent major surgery, or who are receiving interacting medications. (see product PI for list of interacting medications) ▪ Non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days. ▪ Link to PA Form for Antifungals for Onychomycosis

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ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Antifungals		
clotrimazole OTC and RX econazole ketoconazole LAMISIL AT cream Lamisil spray miconazole cream, ointment, powder, spray OTC nystatin cream, ointment, powder terbinafine OTC tolnaftate OTC	*AZOLEN TINCTURE OTC (miconazole tincture)* *betenafine OTC* *Benzal HP* *ciclopirox cream, gel, shampoo, suspension* *ciclopirox solution nail lacquer* CL *ERTACZO (sertaconazole)* *EXELDERM (sulconazole)* *FUNGI-NAIL OTC (undecylenic acid)* *FUNGOID tincture OTC (miconazole)* *KETODAN (ketoconazole) foam* *LOTRIMIN ULTRA OTC (butenafine)* *LUZU (luliconazole)* *MENTAX (butenafine)* *NAFTIN (naftifine)* *NIZORAL shampoo (ketoconazole)* *NIZORAL AD shampoo OTC(ketoconazole)* *OXISTAT (oxiconazole)* *PEDIADERM AF (nystatin/emollient)* *PEDIPIROX-4 (ciclopirox)* *VUSION (miconazole/petrolatum/ zinc oxide)* *Zeosorb AF OTC*	▪ A prescription is required for all drugs. ▪ Link to PA Form for Antifungals, Topical (required for Non-Preferred drugs -except antifungal nail lacquers - see below) ▪ Link to PA Form for nail lacquer – for ciclopirox solution, Fungoid tincture ▪ Antifungal nail lacquers will only be approved for patients meeting all of the following criteria: – Diagnosis of onychomycosis (ICD-9=110.1) within the last year – Contraindication to oral itraconazole and terbinafine as defined by presence of heart failure, hepatic impairment or viral hepatitis – Proof from prescriber that therapy is not for cosmetic purposes. ▪ Other non-preferred agents will be approved only after documented failure of the preferred agents within the previous six months.
Antifungal/Steroid Combinations		
nystatin/triamcinolone cream, ointment	*clotrimazole/betamethasone* *KETOCON, KETOCON + PLUS (ketoconazole/hydrocortisone)*	▪ Individual prescriptions for an antifungal and corticosteroid should be used for patients requiring these drug combinations.

ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine solution, tablets loratadine loratadine ODT	*cetirizine capsule OTC* *cetirizine chewable* *cetirizine solution 5mg/5mL OTC* *desloratadine* *fexofenadine tablets* *levocetirizine*	▪ A prescription is required for all drugs. ▪ Link to PA Form for Antihistamines, Minimally Sedating (required for Non-Preferred drugs) ▪ Non-preferred agents will be authorized if a patient has failed a preferred agent within the most recent six months. ▪ Cetirizine solution is available for patients ≤ 12 years

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ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CATAPRES TTS (clonidine transdermal) clonidine guanfacine methyldopa	*clonidine transdermal* *CLORPRES (chlorthalidone/clonidine)* *methyldopa-hydrochlorothiazide* *reserpine*	▪ Non-preferred agents will be approved only after documented failure of the preferred agent.

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol probenecid probenecid/colchicine	*COLCRYS (colchicine)* [CL] *ULORIC (febuxostat)*[CL]	▪ Link to PA Form for Antihyperuricemics, Oral (required for Non-Preferred drugs) ▪ Uloric will be approved for continuation of gout attacks with serum urate levels >6 mg/dl after at least three months of allopurinol at a therapeutic dose or with documented intolerance to allopurinol. ▪ Colcrys: – A prescription for three tablets does not require prior authorization if processed by the pharmacy as an Emergency Override. – For acute gout, Colcrys will be approved if there is a failure of or contraindication to NSAIDS or corticosteroids. – For chronic gout, Colcrys will be approved for patients on concomitant allopurinol who have failed or have documented intolerance to NSAIDs.

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ANTIMIGRAINE AGENTS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
rizatriptan MLT tablets preferred for ages 6-12 only RELPAX (eletriptan) sumatriptan	*AXERT (almotriptan)* *CAMBIA (diclofenac)* *FROVA (frovatriptan)* *naratriptan* *rizatriptan MLT (age > 12)* *rizatriptan oral tablets* *TREXIMET (sumatriptan/naproxen)* *zolmitriptan*	▪ Link to PA Form for Triptans (required for all drugs) ▪ Rizatriptan MLT tablets will be approved for pediatric patients (6-11 years) who have a diagnosis of migraines. Triptans will be approved for patients meeting all of the following criteria: – No history of CAD, angina, uncontrolled HPT, CVD, PVD, ischemic bowel disease ▪ Treximet will be approved if patient has tried and failed therapy with separate prescriptions for sumatriptan and naproxen. ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with all of the preferred agents within the last 6 months.
Nasal		
IMITREX (sumatriptan)	*sumatriptan* *ZOMIG (zolmitriptan)*	▪ Link to PA Form for Triptans (required for all drugs) ▪ Preferred Triptans will be approved for patients meeting all of the following criteria: – No history of CAD, angina, uncontrolled HPT, CVD, PVD, ischemic bowel disease ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with all of the preferred agents within the last 6 months.

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ANTIMIGRAINE AGENTS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Injectable		
IMITREX (sumatriptan) syringe sumatriptan vial	*ALSUMA (sumatriptan)* *sumatriptan syringe* *SUMAVEL DOSEPRO (sumatriptan)*	▪ Link to PA Form for Triptans (required for all drugs) ▪ Triptans will be approved for patients meeting all of the following criteria: – No history of CAD, angina, uncontrolled HPT, CVD, PVD, ischemic bowel disease ▪ Treximet will be approved if patient has tried and failed therapy with separate prescriptions for sumatriptan and naproxen. ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with all of the preferred agents within the last 6 months.

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
permethrin OTC and Rx ULESFIA (benzyl alcohol)	*EURAX (crotamiton) lotion & cream* *lindane* *malathion* *piperonyl butoxide and pyrethrins OTC* *SKLICE (ivermectin)* *spinosad*	▪ Link to PA Form for Antiparasitics, Topical (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of the preferred agent.

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ANTIPARKINSON'S DRUGS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
benztropine trihexyphenidyl		▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of the preferred agent.
COMT Inhibitors		
	entacapone *TASMAR (tolcapone)*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of the preferred agent.
Dopamine Agonists		
bromocriptine pramipexole ropinirole	*MIRAPEX ER (pramipexole)* *NEUPRO transdermal patch (rotigotine)* *ropinirole ER*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
MAO-B Inhibitors		
selegiline	*AZILECT (rasagiline)* *ZELAPAR (selegiline disintegrating tablets)*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of the preferred agent.
Other Antiparkinson's Drugs		
carbidopa/levodopa tablets carbidopa/levodopa ER STALEVO (carbidopa/levodopa/entacapone)	*carbidopa* *carbidopa/levodopa ODT* *carbidopa/levodopa/entacapone*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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ANTIPSYCHOTICS, FIRST GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
chlorpromazine fluphenazine haloperidol loxapine ORAP (pimozide) perphenazine perphenazine/amitriptyline thiothixene trifluoperazine	*ADASUVE (loxapine)* [CL] *thioridazine*	▪ Link to PA Form for Non-Preferred Drugs ▪ A non-preferred agent will be approved only after documented failure of a preferred agent.
Injectable (Acute Treatment)		
haloperidol lactate		
Injectable (Maintenace Treatment)		
fluphenazine deconate haloperidol deconate		

ANTIPSYCHOTICS, SECOND GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
ABILIFY (aripiprazole) clozapine clozapine ODT LATUDA (lurasidone) olanzapine olanzapine ODT quetiapine risperidone solution, tablets SEROQUEL XR (quetiapine) ziprasidone	*ABILIFY DISCMELT (aripiprazole)* *FANAPT (iloperidone)* *FAZACLO (clozapine)* *INVEGA (paliperidone)* *olanzapine/fluoxetine (must use individual agents)* *risperidone ODT* *SAPHRIS (asenapine)* *VERSACLOZ (clozapine)*	▪ Link to PA Form for Non-Preferred Drugs ▪ A non-preferred agent will be approved only after documented failure of a preferred agent.
Injectable (Acute Treatment)		
ABILIFY (aripiprazole) GEODON (ziprasidone) olanzapine		
Injectable (Maintenance Treatment)		
INVEGA SUSTENNA (paliperidone) RISPERDAL CONSTA (risperidone)	*ABILIFY MAINTENA (aripiprazole)* *ZYPREXA RELPREVV (olanzapine)*	▪ Zyprexa Relprevv (olanzapine) is reimbursed as a medical benefit only and not dispensed through the outpatient pharmacy program.

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ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Antiherpetic Drugs		
acyclovir valacyclovir	*famciclovir*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Antiinfluenza Drugs		
amantadine capsule, tablet and syrup RELENZA (zanamivir) TAMIFLU (oseltamivir)	*rimantadine*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DENAVIR (penciclovir) ZOVIRAX (acyclovir) Ointment[CL]	*acyclovir ointment* *XERESE (acyclovir/hydrocortisone)* *ZOVIRAX (acyclovir) Cream*	▪ Link to PA Form for Antivirals, Topical (required for Non-Preferred Drugs) ▪ Zovirax Ointment will be authorized for patients with a diagnosis of genital herpes.

BETA BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Beta Blockers		
atenolol bisoprolol metoprolol nadolol propranolol propranolol ER sotalol TOPROL XL (metoprolol XL)	*acebutolol* *betaxolol* *BYSTOLIC (nebivolol)* *INDERAL XL (propranolol)* *INNOPRAN XL (propranolol)* *LEVATOL (penbutolol)* *metoprolol XL* *pindolol* *timolol*	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with documented failure to one of the preferred agents within the past 6 months.
Beta Blocker/Diuretic Combinations		
atenolol/chlorthalidone bisoprolol/HCTZ propranolol/HCTZ	*DUTOPROL (metoprolol succinate/HCTZ)* *metoprolol/HCTZ* *nadolol/bendroflumethiazide*	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with documented failure to one of the preferred agents within the past 6 months.
Beta- and Alpha- Blockers		
carvedilol labetalol	*COREG CR (carvedilol)*	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved

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BETA BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		for patients with documented failure to one of the preferred agents within the past 6 months.

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
oxybutynin ER oxybutynin IR TOVIAZ (fesoterodine) VESICARE (solifenacin)	*ENABLEX (darifenacin)* *flavoxate* *GELNIQUE (oxybutynin)* *MYRBETRIQ (mirabegron)* *OXYTROL transdermal (oxybutynin)* *tolterodine* *tolterodine ER* *trospium ER* *trospium*	▪ Link to PA Form for Urinary Incontinence Drugs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Bisphosphonates		
alendronate tablets	*ACTONEL (risedronate)* *alendronate solution* *ACTONEL with calcium* *ATELVIA (risedronate)* *BINOSTO (alendronate)* *ibandronate* *etidronate* *FOSAMAX Plus D (alendronate/cholecalciferol)* *risendronate*	▪ Link to PA Form for Bone Resorption Suppression and Related Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent – ICD-9 of 733.xx or 733.09 plus history of glucocorticoid prescription use – OR documented failure of a Preferred agent
Other Bone Resorption Suppression and Related Drugs		
	calcitonin-salmon *FORTEO (teriparatide)* [CL] *FORTICAL (calcitonin)* *MIACALCIN (calcitonin)* *PROLIA (denosumab)*	▪ Link to PA Form for Bone Resorption Suppression and Related Agents for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Forteo will also be approved for patients that have a diagnosis of glucocorticoid-induced osteoporosis: ICD-9 of 733.xx or 733.09 plus history of glucocorticoid prescription use OR documented failure of a Preferred agent –

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BOTULINUM TOXINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BOTOX [CL](onabotulinumtoxinA) -except for cervical dystonia MYOBLOC [CL](rimabotulinumtoxinB) XEOMIN [CL](incobotulinumtoxinA)	*BOTOX [CL](onabotulinumtoxinA) -(for cervical dystonia* *DYSPORT [CL](abobotulinumtoxinA)*	

BPH TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Alpha Blockers		
alfuzosin doxazosin tamsulosin terazosin	*CARDURA XL (doxazosin)* *RAPAFLO (silodosin)*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
5-Alpha-Reductase (5AR) Inhibitors		
finasteride 5 mg tablet	*AVODART (dutasteride)*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Combination Agents		
	JALYN (dutasteride/tamsulosin)	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Inhalers, Short-Acting		
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	*MAXAIR (pirbuterol)* *VENTOLIN HFA (albuterol)* *XOPENEX HFA (levalbuterol)*	▪ Link to PA Form for Short-Acting Beta-2 Agonists (required for Non-preferred drugs) ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Bronchodilators, Beta Agonist Inhalers, Long-Acting		
	ARCAPTA (indacaterol) [CL] *FORADIL (formoterol)* *SEREVENT (salmeterol)* *STRIVERDI RESPIMAT (olodaterol)*	▪ Link to PA Form for Long-Acting Beta-2 Agonists (required for Non-Preferred drugs) ▪ Long-acting beta agonist inhalers will be approved for participants meeting the following criteria ❖ Concurrent (i.e., active therapy on the in-process claim date) use of a short-acting beta-2-agonist MDI or nebulizer in the last 30 days **PLUS** ❖ Age >17 years old **PLUS** ❖ Diagnosis of chronic obstructive

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BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		pulmonary disease (COPD) ,chronic bronchitis and emphysema (ICD-9 = 491.xx, 492.xx, 493.xx, 496.xx) ***OR*** ❖ Concomitant inhaled corticosteroid use
Inhalation Solution		
albuterol	*levalbuterol* *BROVANA (arformoterol)* *PERFOROMIST (formoterol)*	▪ Link to PA Form for Short-Acting Beta-2 Agonists (levalbuterol) (required for Non-preferred drugs) ▪ Link to PA Form for Long-Acting Beta-2 Agonists (Brovana/Perforomist) (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Long-acting beta agonist inhalers will be approved for participants meeting the following criteria ❖ Concurrent (i.e., active therapy on the in-process claim date) use of a short-acting beta-2-agonist MDI or nebulizer in the last 30 days **PLUS** ❖ Age >17 years old **PLUS** ❖ Diagnosis of chronic obstructive pulmonary disease (COPD) ,chronic bronchitis and emphysema (ICD-9 = 491.xx, 492.xx, 493.xx, 496.xx) ***OR*** ▪ Concomitant inhaled corticosteroid use
Oral		
terbutaline	*albuterol* *albuterol ER* *metaproterenol*	▪ Link to PA Form for Beta-2 Agonists (required for Non-Preferred drugs) ▪ The non-preferred agent will be approved only after documented failure of a preferred agent. ▪ Long-acting beta agonist inhalers will be approved for participants meeting the following criteria ❖ Concurrent (i.e., active therapy on the in-process claim date) use of a short-acting beta-2-agonist MDI or nebulizer in the last 30 days **PLUS** ❖ Age >17 years old **PLUS** ❖ Diagnosis of chronic obstructive pulmonary disease (COPD) ,chronic bronchitis and emphysema (ICD-9 = 491.xx, 492.xx, 493.xx, 496.xx) ***OR*** ❖ Concomitant inhaled corticosteroid use

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CALCIUM CHANNEL BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Short-Acting		
diltiazem nifedipine verapamil	*isradipine* *nicardipine*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Long-Acting		
amlodipine diltiazem ER nifedipine ER nimodipine verapamil ER (except 360 mg caps)	*CARDENE SR (nicardipine)* *COVERA-HS (verapamil)* *diltiazem LA* *DYNACIRC CR (isradipine)* *felodipine ER* *nisoldipine* *NYMALIZE (nimodipine)* *TIAZAC (diltiazem) 420 mg* *verapamil ER PM* *verapamil 360 mg caps*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

CEPHALOSPORINS AND RELATED AGENTS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Beta Lactam/Beta-Lactamase Inhibitor Combinations		
amoxicillin/clavulanate IR amoxicillin/clavulanate suspension AUGMENTIN suspension (amoxicillin/clavulanate) 125 mg/5 mL	*amoxicillin/clavulanate XR*	▪ Link to PA Form for Cephalosporins & Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – First Generation		
cefadroxil capsule, suspension cephalexin	*cefadroxil tablet*	▪ Link to PA Form for Cephalosporins & Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – Second Generation		
cefprozil cefuroxime	*Cefaclor* *CEFTIN SUSPENSION (cefuroxime)*	▪ Link to PA Form for Cephalosporins & Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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CEPHALOSPORINS AND RELATED AGENTS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cephalosporins – Third Generation		
cefdinir SUPRAX (cefixime) capsule, suspension	*ceftibuten capsule, suspension* *cefditoren* *cefpodoxime* *SUPRAX (cefixime) chew tab and tablet*	▪ Link to PA Form for Cephalosporins & Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GRANIX (tbo-filgastim) LEUKINE (sargramostim) NEUPOGEN (filgrastim) NEULASTA (pegfilgrastim)		

COPD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
ATROVENT HFA (ipratropium) ipratropium nebulizer solution SPIRIVA (tiotropium)	*TUDORZA PRESSAIR (aclidinium)*	
Anticholinergic-Beta Agonist Combinations		
albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium)	*ANORO ELLIPTA (umeclidium/vilanterol)*	
PDE-4 Inhibitors		
	DALIRESP (roflumilast)[CL]	▪ Daliresp will be approved for adults with severe COPD associated with chronic bronchitis and a history of exacerbations

COUGH AND COLD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
benzonatate capsules hydrocodone/chlorpheniramine suspension hydrocodone/homatropine syrup, tablets promethazine/codeine syrup promethazine/dextromethorphan syrup	*All other products are non-preferred* *Products containing decongestants are excluded from coverage*	▪ Restricted to recipients >6 years of age. ▪ Quantity limits of 4 oz per prescription and no more than two prescriptions per 6 months apply.

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ENBREL (etanercept) HUMIRA (adalimumab)	*ACTEMRA (tocilizumab)* *AMEVIVE (alefacept)* *ARCALYST (rilonacept)* *CIMZIA (certolizumab)* *ENTYVIO(vedolizumab)* *ILARIS (canakinumab)* *KINERET (anakinra)* *ORENCIA (abatacept)* *OTEZLA (apremilast)* *REMICADE (infliximab)* *SIMPONI (golimumab)* *STELARA (ustekinumab)* *XELJANZ (tofacitinib)*	▪ Link to PA Form for Cytokine & CAM Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

EPINEPHRINE, SELF-INJECTED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
EPIPEN EPIPEN JR	*AUVI-Q* *epinephrine*	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbepoetin) PROCRIT (rHuEPO)	*EPOGEN (rHuEPO)*	▪ Link to PA Form for Erythropoiesis Stimulating Proteins ▪ Epogen will only be authorized if there is documented failure of one preferred agent within the past 180 days

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin CIPRO Suspension (ciprofloxacin) levofloxacin tablets	*ciprofloxacin ER* *levofloxacin solution* *moxifloxacin* *NOROXIN (norfloxacin)* *ofloxacin*	▪ Link to PA Form for Fluoroquinolones (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Glucocorticoids	
FLOVENT (fluticasone) PULMICORT Respules 0.25 & 0.5 mg (budesonide) PULMICORT FLEXHALER (budesonide) QVAR (beclomethasone)	*AEROSPAN (flunisolide)* *ALVESCO (ciclesonide)* *ASMANEX (mometasone)* *budesonide respules 0.25 & 0.5 mg* *PULMICORT Respules 1.0 mg (budesonide)*	▪ Link to PA Form for Inhaled Glucocorticoids (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.

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GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Glucocorticoid/Bronchodilator Combinations[CL]		
ADVAIR (fluticasone/salmeterol) SYMBICORT (budesonide/formoterol)	*BREO ELLIPTA(fluticasone/vibanterol)* *DULERA (mometasone/formoterol)*	▪ Link to PA Form for Inhaled Glucocorticoid/Bronchodilator Combinations (required for all drugs) ▪ Asthma: Glucocorticoid/bronchodilator combinations will be approved for eligible participants with a documented diagnosis of persistent asthma and have tried and failed an inhaled glucocorticoid. ▪ COPD: Advair Diskus 250/50 will be approved for eligible participants with a diagnosis of Stage III or Stage IV COPD with repeated exacerbations and a failure of a long acting beta agonist inhaler (Foradil or Serevent).

GROWTH FACTORS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INCRELEX (mecasermin) [CL]		

GROWTH HORMONE[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	*GENOTROPIN (somatropin)* *HUMATROPE (somatropin)* *OMNITROPE (somatropin)* *SAIZEN (somatropin)* *SEROSTIM (somatropin)* *TEV-TROPIN (somatropin)* *ZORBTIVE (somatropin)*	▪ Link to PA Form for Growth Hormone (required for all drugs) ▪ Growth hormone will be approved for patients with any of the following diagnoses and meeting the criteria defined on the PA Form: – Chronic Renal Impairment awaiting renal transplantation (ICD-9 585) – Growth Hormone Deficiency (ICD-9=253.2, 253.3) – Prader-Willi Syndrome (ICD-9=759.81) – Turner Syndrome (ICD-9=758.6) – HIV plus Cachexia (ICD-9=042, 079.53, V08 or 795.71 plus 799.4) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with the preferred agents within the last 6 months.

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H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline) HELIDAC (bismuth subsalicylate, metronidazole, tetracycline)	*OMECLAMOX-PAK (omeprazole, amoxicillin, clarithromycin)* *lansoprazole, amoxicillin, clarithromycin*	▪ Non-preferred agents will only be approved after documented failure of a preferred agent.

HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Factor VIII, Plasma Derived	
KOATE-DVI MONOCLATE-P	*CORIFACT* *HEMOFIL-M*	
	Factor VIII, Recombinant	
ADVATE RECOMBINATE	*ELOCTATE* *HELIXATE FS* *KOGENATE FS* *XYNTHA*	
	Factor IX, Plasma Derived	
ALPHANINE SD BEBULIN PROFILNINE SD	*MONONINE*	
	Factor IX, Recombinant	
BENEFIX	ALPROLIX RIXUBIS	
	Factor VIII/Von Willibrand, Plasma Derived	
HUMATE-P	ALPHANATE WILATE	
	Coagulation Factor VIIa, Recombinant	
NOVOSEVEN RT		
	Coagulation Factor XIII A-Subunit, Recombinant	
	TRETTEN	
	Anti-inhibitor Coagulant Complex	
	FEIBA NF	

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HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Interferon		
PEGASYS (pegylated interferon alfa-2a) PEG-INTRON (pegylated interferon alfa-2b)	*INFERGEN (consensus interferon)*	▪ Link to PA Form for Hepatitis C - Interferon and Ribavirin (required for Non-preferred drugs) ▪ The non-preferred agent will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.
Ribavirin		
ribavirin	*RIBAPAK (ribavirin)* *RIBASPHERE (ribavirin)* *ribavirin dose pack*	▪ Link to PA Form for Hepatitis C - Interferon and Ribavirin (required for Non-preferred drugs) ▪ The non-preferred agent will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.
Protease Inhibitors[CL]		
	OLYSIO (simeprevir) [CL] *SOVALDI (sofosbuvir)* [CL] *VICTRELIS (boceprevir)*	▪ Link to PA Form for Non-Preferred drug ▪ The non-preferred agent will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.

HERIDITARY ANGIOEDEMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CINRYZE (C1- esterase inhibitor) [CL] FIRAZYR (icatibant) [CL] KALBITOR (ecallantide) [CL]	*BERINERT (C1-esterase inhibitor)* [CL]	

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INCRETIN ENHANCERS		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) TRADJENTA (linagliptin)	*KAZANO (alogliptin/metformin)* *NESINA (alogliptin)* *OSENI (alogliptin/pioglitazone)*	▪ The non-preferred agent will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.
INCRETIN MIMETICS		
BYETTA (exenatide) SYMLIN (pramlintide)	*BYDUREON (exenatide ER)* *VICTOZA (liraglutide)*	▪ Link to PA Form for Hypoglycemics, Incretin Mimetics for Byetta and Victoza. ▪ Byetta will be approved for patients with

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		type 2 diabetes ▪ Link to PA Form for Symlin ▪ Symlin will be approved for patients with diabetes who are currently on insulin therapy. ▪ Symlin will not be approved for pediatric patients <6 years of age or for patients with a diagnosis of gastroparesis or who require the use of medication to stimulate gastric motility.

HYPOGLYCEMICS, INSULIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	*APIDRA (insulin glulisine)* *NOVOLIN (insulin)*	▪ Link to PA Form for Insulin (required for Non-preferred drugs) ▪ Apidra will be approved for patients with documented hypoglycemia with Humalog or NovoLog. ▪ Patients currently on a non-preferred drug will be grandfathered.

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PRANDIN (repaglinide) STARLIX (nateglinide)	*nateglinide* *PRANDIMET (repaglinide/metformin)* *repaglinide*	

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	INVOKANA (canagliflozin) *FARXIGA (dapagliflozin)*	

HYPOGLYCEMICS, TZDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Thiazolidinediones	
pioglitazone	*AVANDIA (rosiglitazone)*	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
	Thiazolidinedione Combinations	
	pioglitazone/metformin *ACTOPLUS MET XR (pioglitazone/metformin)* *AVANDAMET (rosiglitazone/metformin)*	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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HYPOGLYCEMICS, TZDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	AVANDARYL (rosiglitazone/glipizide) *pioglitazone/glimepiride*	

IMMUNOMODULATORS FOR ATOPIC DERMATITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus)	*PROTOPIC (tacrolimus)*	▪ Black box warning - Not indicated for children less than two years of age. ▪ The non-preferred agent will be approved after failure of the preferred agent.

IMMUNE GLOBULINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CYTOGAM (cytomegalovirus immune globulin) intravenous solution FLEBOGAMMA DIF intravenous solution GAMASTAN S/D intramuscular GAMMAGARD LIQUID injection solution GAMMAGARD S/D powder for intravenous solution GAMMAPLEX intravenous solution GAMUNEX-C injection solution HEPAGAM B (hepatitis B immune globulin) intramuscular HIZENTRA subcutaneous solution PRIVIGEN intravenous solution VARIG (Varicella-Zoster immune globulin) intramuscular	*BIVIGAM intravenous solution* *CARIMUNE NF nano filtered powder for intravenous solution* *GAMMAGARD S/D powder for intravenous solution* *GAMMAKED injection solution* *OCTAGAM intravenous solution*	▪ Preferred immune globulin products will be approved for FDA indications or for diagnoses that have evidence-based documentation to support their usage for which there are no therapeutic alternatives. Usual age, dosage, and frequency limitations apply as well as reasonable dosage rounding (+/- 10%) to utilize whole vials to minimize wastage. ▪ Non-preferred agents require either trial and failure of a preferred agent or documentation of medical necessity.

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine cyclosporine capsule cyclosporine softgel cyclosporine, modified mycophenolate mofetil NEORAL (cyclosporine, modified) PROGRAF (tacrolimus)	*ASTRAGRAF (tacrolimus XL)* *mycophenolic acid* *SANDIMMUNE (cyclosporine)* *sirolimus (0.5 mg tabs)* *RAPAMUNE (sirolimus 0.5, 1 and 2 mg tabs)* *tacrolimus* *ZORTRESS (everolimus)*	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
ipratropium		▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ The non-preferred agents will be approved only after documented failure of the preferred agent
Antihistamines		
ASTEPRO (azelastine) PATANASE (olopatadine)	*ASTELIN (azelastine)* *azelastine*	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ The non-preferred agents will be approved only after documented failure of the preferred agent
Corticosteroids		
fluticasone NASONEX (mometasone)	*BECONASE AQ (beclomethasone)* *budesonide* *flunisolide* *NASACORT AQ (triamcinolone)* *OMNARIS (ciclesonide)* *QNASL (beclomethasone)* *RHINOCORT AQUA (budesonide)* *triamcinolone* *VERAMYST (fluticasone)* *ZETONNA (ciclesonide)*	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ The non-preferred agents will be approved only after documented failure of the preferred agent
Antihistamine / Corticosteroid Combinations		
	DYMISTA (azelastine/fluticasone)	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ The non-preferred agents will be approved only after documented failure of the preferred agent

IRRITABLE BOWEL SYNDROME

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone) LINZESS (linaclotide)	*LOTRONEX (alosetron)*	

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACCOLATE (zafirlukast) montelukast tabs and chew tab	*montelukast granules* *zafirlukast* *ZYFLO CR (zileuton)*	▪ Link to PA Form for Leukotriene Modifiers (required for Non-Preferred drugs) ▪ The non-preferred agents will be approved only after documented failure of the preferred agent.

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LIPOTROPICS, OTHER (NON-STATINS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Apolipoprotein B Synthesis Inhibitors		
	JUXTAPID (lomitapide mesylate) [CL] *KYNAMRO (mipomersen)* [CL]	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for Zetia - see below)
Bile Acid Sequestrants		
cholestyramine	*colestipol* *WELCHOL (colesevelam)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for Zetia - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Fibric Acid Derivatives		
fenofibrate capsules 67, 134, and 200 mg (generic LOFIBRA) fenofibrate tablets 54 and 160 mg (generic LOFIBRA) fenofibrate 48 and 145 mg tablets (generic TRICOR) fenofibric acid 45 and 135 mg DR capsules (generic TRILIPIX DR) gemfibrozil 600 mg	*ANTARA (fenofibrate) 43 and 130 mg* *fenofibrate 43, 130 mg (generic ANTARA)* *FIBRICOR (fenofibric acid)* *LIPOFEN (fenofibrate)* *TRIGLIDE (fenofibrate)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for Zetia - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent
Niacin		
NIACOR (niacin) NIASPAN (niacin)		▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs -except for Zetia - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Omega-3 Fatty Acids		
	LOVAZA (omega-3 fatty acids) *VASCEPA (icosapent ethyl)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for Zetia - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cholesterol Absorption Inhibitors[CL]		
	ZETIA (ezetimibe)	▪ Link to PA Form for Zetia ▪ Zetia will be approved for patients who have a diagnosis of hypercholesterolemia and have either failed statin monotherapy or have a documented intolerance to statins. ▪ Zetia treatment is only approved as an adjunct to concurrent statin therapy unless there is a documented intolerance to the statins.

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LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		
atorvastatin lovastatin pravastatin simvastatin	*ALTOPREV (lovastatin)* *CRESTOR (rosuvastatin)* *fluvastatin* *LESCOL (fluvastatin)* *LESCOL XL (fluvastatin)* *LIVALO (pitavastatin)*	▪ Link to PA Form for Statins (required for Non-Preferred drugs-except Vytorin - see below) ▪ Non-preferred agents will be approved after documented failure of two preferred agents for a total of ≥150 days in the last six months
Statin Combinations		
	ADVICOR (lovastatin/niacin) *atorvastatin/ amlodipine* *LIPTRUZET (atorvastatin/ezetimibe)* *SIMCOR (simvastatin/niacin ER)* *VYTORIN (simvastatin/ezetimibe)*[CL]	▪ Link to PA Form for Statins (required for Non-Preferred drugs - except Vytorin – see below) ▪ Non-preferred agents will be approved after documented failure of two preferred agents for a total of ≥150 days in the last six months ▪ Link to PA Form for Vytorin ▪ Vytorin will be approved for patients failing a minimum 3 month trial of standard dose statin.

MACROLIDES AND KETOLIDES (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Ketolides		
	KETEK (telithromycin)	▪ Link to PA Form for Macrolides & Ketolides (required for Non-Preferred drugs) ▪ Ketek will be approved if there is documentation of any antibiotic use within the past 28 days and only for community acquired pneumonia.
Macrolides		
azithromycin clarithromycin IR tablets ERY-TAB (erythromycin) E.E.S. 200 mg suspension (erythromycin ethylsuccinate) PCE (erythromycin)	*clarithromycin ER* *clarithromycin suspension* *E.E.S. 400 mg tablets (erythromycin ethylsuccinate)* *ERYPED suspension (erythromycin ethylsuccinate)* *erythromycin base* *erythromycin stearate* *ZMAX (azithromycin suspension)*	▪ Link to PA Form for Macrolides and Ketolides (required for Non-Preferred drugs) ▪ Other non-preferred agents will be approved only after documented failure of a preferred agent.

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MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Disease Modifying Therapies		
AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20 mg syringe (glatiramer) REBIF (interferon beta-1a)	*AUBAGIO (teriflunomide)* CL *COPAXONE 40 mg syringe (glatiramer)* *EXTAVIA (interferon beta-1b)* *GILENYA (fingolimod)* CL *REBIF REBIDOSE (interferon beta-1a)* *TECFIDERA (dimethyl fumarate)* CL	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Other		
	AMPYRA (dalfampridine) CL	

NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Nonselective		
diclofenac IR diclofenac SR etodolac IR flurbiprofen ibuprofen* INDOCIN Suspension (indomethacin) indomethacin IR ketoprofen IR ketorolac nabumetone naproxen* naproxen EC piroxicam sulindac	*diflunisal* *etodolac SR* *fenoprofen* *INDOCIN (indomethacin) rectal* *indomethacin ER* *ketoprofen ER* *meclofenamate* *mefenamic acid* *NAPRELAN (naproxen)* *oxaprozin* *SPRIX nasal (ketorolac)* *tolmetin* *ZIPSOR (diclofenac)* *ZORVOLEX (diclofenac)*	▪ Link to PA Form for NSAIDs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ * Prescription strength only; OTC ibuprofen and OTC naproxen are not covered by Idaho Medicaid.
NSAID/GI Protectant Combinations		
	diclofenac/misoprostol *VIMOVO (naproxen/esomeprazole)* *DUEXIS (ibuprofen/famotidine)*	▪ Individual prescriptions for naproxen and esomeprazole should be used for patients requiring the combination drug Vimovo.

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NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-II Selective		
meloxicam tablets MOBIC Suspension (meloxicam)	*CELEBREX (celecoxib)*[CL] *meloxicam suspension*	▪ Link to PA Form for COX-2 Selective NSAIDs for Celebrex ▪ Celebrex will be approved for patients with rheumatoid arthritis, osteoarthritis, acute pain or dysmenorrhea and who have any of the following risk factors for a GI bleed: – previous or current PUD or GI bleed – concurrent therapy with corticosteroids, anticoagulants or antiplatelets – inability to tolerate at least two nonselective NSAIDs ▪ Celebrex will be approved for patients with Familial Adenomatous Polyposis ▪ Acute pain treatment is limited to 14 days
NSAIDS, TOPICAL		
VOLTAREN GEL (diclofenac) [CL]	*diclofenac solution 1.5%* *FLECTOR (diclofenac)* [CL] *PENNSAID 2% (diclofenac)* [CL]	▪ Link to PA form for Analgesics, Topical (required for all drugs in class) Flector Patch will be approved for one fill of 15 days for patients meeting the following criteria: – Diagnosis of acute pain due to minor strains, sprains, and contusion – History of preferred oral NSAID within the past 15 days – No history of a Flector Patch in the last 90 days ▪ Pennsaid will be approved for patients meeting the following criteria: – Diagnosis of osteoarthritis of the knee – History of preferred oral NSAID within the past 15 days ▪ Voltaren Gel will be approved for patients meeting the following criteria: ❖ Diagnosis of osteoarthritis of either the hand or knee ❖ History of preferred oral NSAID within the past 15 days

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OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BLEPHAMIDE suspension (prednisolone/sulfacetamide) BLEPHAMIDE S.O.P. ointment (prednisolone/sulfacetamide) neomycin/polymyxin/dexamethasone PRED-G (gentamicin/prednisolone) sulfacetamide/prednisolone TOBRADEX Ointment (tobramycin/dexamethasone) TOBRADEX Suspension	*neomycin/bacitracin/polymyxin/ hydrocortisone* *neomycin/polymyxin/HC* *TOBRADEX ST (tobramycin/dexamethasone)* *tobramycin/dexamethasone suspension* *ZYLET (loteprednol/tobramycin)*	• Link to PA Form for Ophthalmic Antibiotic-Steroid Combinations (required for Non-preferred drugs). • Non-preferred agents will be approved for participants failing to respond to a preferred agent.

OPHTHALMIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin/polymyxin CILOXAN Ointment (ciprofloxacin) ciprofloxacin erythromycin gentamicin MOXEZA (moxifloxacin) ofloxacin polymyxin/trimethoprim sulfacetamide solution tobramycin solution TOBREX Ointment (tobramycin) VIGAMOX (moxifloxacin)	*AZASITE (azithromycin)* *bacitracin* *BESIVANCE (besifloxacin)* *CILOXAN Solution (ciprofloxacin)* *gatifloxacin* *IQUIX (levofloxacin)* *levofloxacin* *NATACYN (natamycin)* *neomycin/bacitracin/polymyxin* *neomycin/polymyxin/gramicidin* *sulfacetamide ointment* *ZYMAXID (gatifloxacin)*	▪ Link to PA Form for Ophthalmic Antibiotics (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALREX (loteprednol) cromolyn PATADAY (olopatadine)	*ALOCRIL (nedocromil)* *ALOMIDE (lodoxamide)* *azelastine* *BEPREVE (bepotastine)* *EMADINE (emedastine)* *epinastine* *ketotifen RX* *LASTACAFT (alcaftadine)* *OPTIVAR (azelastine)* *PATANOL (olopatadine)*	▪ Link to PA Form for Ophthalmics for Allergic Conjunctivitis (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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OPHTHALMIC ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
dexamethasone diclofenac DUREZOL (difluprednate) FLAREX (fluorometholone) fluorometholone flurbiprofen ketorolac 0.5 % ketorolac LS 0.4% LOTEMAX drops (loteprednol) MAXIDEX (dexamethasone) PRED MILD (prednisolone acetate) prednisolone acetate	*ACUVAIL (ketorolac 0.45%)* *bromfenac* *FML FORTE (fluorometholone)* *FML S.O.P. (fluorometholone)* *ILEVRO (nepafenac)* *LOTEMAX gel and ointment (loteprednol)* *NEVANAC (nepafenac)* *PRED FORTE (prednisolone acetate)* *prednisolone sodium phosphate* *PROLENSA (bromfenac)* *VEXOL (rimexolone)*	▪ Link to PA Form for Ophthalmic Anti-Inflammatories (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

OPHTHALMICS, GLAUCOMA DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Parasympathomimetics		
pilocarpine	*PILOPINE-HS (pilocarpine gel)*	▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Sympathomimetics		
ALPHAGAN P 0.15% (brimonidine) brimonidine 0.1%	*apraclonidine* *brimonidine P 0.15%*	▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Beta Blockers		
betaxolol 0.5% solution BETIMOL (timolol) BETOPTIC S (betaxolol 0.25% suspension) carteolol ISTALOL (timolol maleate) levobunolol metipranolol timolol		▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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OPHTHALMICS, GLAUCOMA DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Carbonic Anhydrase Inhibitors		
AZOPT (brinzolamide) dorzolamide		▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Prostaglandin Analogs		
latanoprost TRAVATAN Z (travoprost)	*LUMIGAN (bimatoprost)* *RESCULA (unoprostone)* *travoprost* *ZIOPTAN (tafluprost)*	▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Combination Drugs		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)		▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

OPIATE DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
buprenorphine naltrexone (oral) SUBOXONE film (buprenorphine/naloxone)	*buprenorphine/naloxone sublingual tablets* *ZUBSOLV (buprenorphine/naloxone tablet)*	▪ Link to PA Form for Suboxone/buprenorphine ▪ Idaho Medicaid participants receiving Suboxone (buprenorphine/naloxone) or buprenorphine will be blocked by Idaho Medicaid for payment of any other opioids

OTIC ANTI-INFECTIVES AND ANESTHETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acetic acid acetic acid/aluminum	*acetic acid/hydrocortisone*	▪ Link to PA Form for Otic Anti-Infectives & Anesthetics (required for Non-Preferred drugs).

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRO HC (ciprofloxacin/hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone) COLY-MYCIN S (colistin/neomycin/HC) CORTISPORIN TC (colistin/neomycin/HC) neomycin/polymyxin/hydrocortisone ofloxacin	*ciprofloxacin* *CORTISPORIN (hydrocortisone/neomycin sulfate/polymyxin B sulfate)*	▪ Link to PA Form for Otic Antibiotics (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON pancrelipase ZENPEP	*PANCREAZE* *PERTZYE* *ULTRESA* *VIOKACE*	▪ Link to PA Form for Pancreatic Enzymes ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent within the last 6 months

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl)	*ELIPHOS (calcium acetate)* *FOSRENOL (lanthanum)* *PHOSLO (calcium acetate)* *RENVELA (sevelamer carbonate)* *VELPHORO (sucroferric oxyhydroxide)*	▪ Link to PA Form for Phosphate Binders (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
dipyridamole clopidogrel	*AGGRENOX (dipyridamole/aspirin)* *BRILINTA (ticagrelor)* *EFFIENT (prasugrel)* *ticlopidine*	▪ Link to PA Form for Platelet Aggregation Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

PROTON PUMP INHIBITORS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NEXIUM suspension (esomeprazole) omeprazole Rx PROTONIX suspension (pantoprazole) pantoprazole	*ACIPHEX sprinkle (rabeprazole)* *DEXILANT (dexlansoprazole)* *esomeprazole strontium* *lansoprazole* *NEXIUM (esomeprazole)* *omeprazole OTC* *omeprazole/sodium bicarbonate* *omeprazole magnesium OTC* *omeprazole suspension* *rabeprazole*	▪ Link to PA Form for PPIs (required for Non-Preferred drugs) ▪ Lansoprazole SoluTab will be authorized for patients meeting one of the following criteria: – age <5 years – has a G-tube – has failed or is not a candidate for capsules ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with all preferred agents within the last 6 months. ▪ Quantity limits of one dose per day apply to this class

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PULMONARY ARTERIAL HYPERTENSION AGENTS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Endothelin Receptor Antagonists, Oral		
LETAIRIS (ambrisentan)	*TRACLEER (bosentan)* *OPSUMIT (macitentan)*	• Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Endothelin Receptor Antagonists, Inhalation		
	TYVASO (treprostinil) *VENTAVIS (iloprost)*	▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
PDE-5 Inhibitors		
sildenafil	*ADCIRCA (tadalafil)*	▪ Adcirca and sildenafil will only be approved for diagnosis of pulmonary artery hypertension (ICD-9 416xx) ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Soluble Guanylate Cyclase Stimulators		
	ADEMPAS (riociguat)	▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Benzodiazepines		
temazepam 15 and 30 mg	*DORAL (quazepam)* *estazolam* *flurazepam* *temazepam 7.5 and 22.5 mg* *triazolam*	▪ Link to PA Form for Sedative Hypnotics (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with at least two preferred agents within the last 6 months. ▪ Treatment naïve patients without behavioral health disorders will be limited to 15 capsules/tablets per month.
Others		
zolpidem IR	*EDLUAR (zolpidem)* *eszopiclone* *HETLIOZ (tasimelteon)* *INTERMEZZO SL (zolpidem)* *LUNESTA (eszopiclone)* *ROZEREM (ramelteon)* *SILENOR (doxepin)* zaleplon *zolpidem ER* *ZOLPIMIST (zolpidem)*	▪ Link to PA Form for Sedative Hypnotics (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with at least two preferred agents within the last 6 months.

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SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen chlorzoxazone cyclobenzaprine IR dantrolene methocarbamol tizanidine tablets	*carisoprodol* [CL] *carisoprodol compound* [CL] *AMRIX (cyclobenzaprine ER)* *LORZONE (chlorzoxazone)* *metaxalone* *orphenadrine* *tizanidine capsules*	▪ Link to PA Form for Skeletal Muscle Relaxants (required for Non-Preferred drugs) ▪ The non-preferred agents will be approved for patients with documented failure of at least a one week trial each of two preferred agents. ▪ For carisoprodol: – use will be limited to no more than 34 days – additional authorization will not be granted for at least six months following the last day of the previous course of therapy – approval will not be granted for patients with a history of meprobamate use in the previous two years – approval will not be granted for patients concurrently using opioids

STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Low Potency		
desonide cream, ointment hydrocortisone cream, gel, lotion, ointment (RX)	*alclometasone dipropionate cream, ointment* *ANTI-ITCH ointment (hydrocortisone acetate) OTC* *AQUA GLYCOLIC HC (hydrocortisone)* *CAPEX shampoo (fluocinolone acetonide)* *DESONATE gel (desonide)* *desonide lotion* *FIRST HYDROCORT gel (hydrocortisone)* *fluocinolone 0.01% in Scalp Oil & Body Oil* *hydrocortisone cream, gel, lotion and ointment OTC* *hydrocortisone acetate cream OTC* *hydrocortisone/aloe cream, gel, ointment* *hydrocortisone/mineral oil/petrolatum ointment (Absorbase)* *PEDIADERM HC (nystatin/hydrocortisone)* *PEDIADERM TA (nystatin/triamcinolone)* *SCALPICIN ANTI-ITCH MAXIMUM STRENGTH LIQUID (hydrocortisone)* *SCALP RELIEF LIQUID (hydrocortisone)*	▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	TEXACORT (hydrocortisone) solution *U-CORT (hydrocortisone acetate/urea)*	
Medium Potency		
hydrocortisone butyrate cream, solution (except ROUSES brand) hydrocortisone valerate cream, ointment mometasone furoate cream, ointment, solution	*betamethasone valerate foam* *clocortolone cream* *CLODERM (clocortolone pivalate)* *CORDRAN TAPE (flurandrenolide)* *DERMATOP (prednicarbate)cream and ointment* *ELOCON Lotion (mometasone furoate solution)* *fluocinolone acetonide cream, ointment, solution* *fluticasone propionate cream lotion, ointment* *hydrocortisone butyrate cream and solution (ROUSES Brand)* *hydrocortisone butyrate emollient* *hydrocortisone butyrate ointment* *hydrocortisone butyrate lipo cream* *MOMEXIN (mometasone cream and ammonium lactate mousse)* *PANDEL (hydrocortisone probutate)* *prednicarbate cream, ointment*	▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
High Potency		
betamethasone dipropionate cream, lotion fluocinonide cream, emollient, gel, ointment, solution triamcinolone acetonide cream, ointment	*amcinonide cream, lotion, ointment* *betamethasone dipropionate/propylene glycol (augmented) cream, lotion, ointment* *betamethasone dipropionate gel, ointment* *betamethasone valerate cream, foam, lotion, ointment* *desoximetasone cream, gel, ointment* *diflorasone diacetate cream, ointment* *HALOG (halcinonide) cream, ointment* *KENALOG AEROSOL SPRAY (triamcinolone acetonide spray)* *TOPICORT (desoximetasone) topical spray* *triamcinolone acetonide lotion* *TRIANEX (triamcinolone acetonide) ointment* *VANOS (fluocinonide) cream*	▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.
Very High Potency		
clobetasol cream, gel, ointment, solution clobetasol emollient cream halobetasol propionate cream, ointment	*APEXICON E (diflorasone diacetate) cream* *clobetasol foam, emollient foam, lotion, shampoo* *CLOBEX (clobetasol) spray* *TEMOVATE (clobetasol) ointment*	▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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STIMULANTS AND RELATED DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADDERALL XR [CL] (amphetamine salt combination) amphetamine salt combination IR [CL] FOCALIN (dexmethylphenidate) [CL] FOCALIN XR (dexmethylphenidate) [CL] METADATE CD (methylphenidate) [CL] methylphenidate IR Tablets methylphenidate ER (generic Ritalin SR) [CL] methylphenidate ER (generic Concerta) [CL] QUILLIVANT XR (methylphenidate) solution [CL] VYVANSE (lisdexamfetamine) [CL]	*amphetamine salt combination ER* [CL] *DAYTRANA (methylphenidate)* [CL] *dexmethylphenidate* [CL] *dexmethylphenidate XR* *dextroamphetamine IR, ER* [CL] *dextroamphetamine sulfate solution* [CL] *METHYLIN Chewable Tablets (methylphenidate)* [CL] *methylphenidate solution* [CL] *methylphenidate CD (generic Metadate CD)* [CL] *methylphenidate ER (generic Ritalin LA)* [CL] *PROCENTRA (dextroamphetamine sulfate solution)* [CL] *ZENZEDI (dextroamphetamine)* [CL]	▪ Link to PA Form for Stimulants - ADD/ADHD Drugs (required for Non-Preferred drugs) ▪ Stimulants will be approved for patients with a diagnosis of ADD/ADHD (ICD-9=314) or narcolepsy (ICC-9=347) in the previous 2 years. ▪ Contraindications for stimulant use include: – opiate abuse – drug dependence, including to opioids, cocaine, amphetamine, hallucinogens – hypertension – hyperthyroidism – glaucoma ▪ Amphetamine salt combination products and dextroamphetamine will be approved only for patients ≥3 years of age. ▪ Dexmethylphenidate, methylphenidate, Focalin and Focalin XR will be approved only for patients >6 years of age. ▪ Daytrana will only be approved for patients who are unable to take oral therapy.
Non-Stimulants		
clonidine guanfacine STRATTERA (atomoxetine) [CL]	*clonidine ER* [CL] *INTUNIV (guanfacine ER)* [CL] *KAPVAY (clonidine ER)* [CL]	▪ Link to PA Form for Strattera) ▪ Strattera will be approved for patients meeting at least one of the following criteria: – documented trial and failure of at least one stimulant within two months – diagnosis of tics or anxiety disorder or a history of substance abuse. ▪ Link to PA Form for Non-Stimulant Therapy for ADHD ▪ Intuniv will be approved for ADHD patients with a failure of guanfacine immediate release ▪ Kapvay will be approved for ADHD patients with a failure of clonidine immediate release

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STIMULANTS AND RELATED DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Narcolepsy-Specific Agents		
	NUVIGIL (armodafinil) [CL] *modafinil* [CL]	▪ Link to PA Form for Nuvigil & Provigil ▪ Provigil and Nuvigil will be approved for patients ≥16 years of age with any of the following diagnoses in the previous 2 years: – diagnosis of narcolepsy (ICD-9=347) – obstructive sleep apnea (ICD-9=780.51, 780.53) – shift work sleep disorder (ICD-9=307.45)

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR minocycline capsules tetracycline	*ADOXA (doxycycline monohydrate)* *demeclocycline* *DORYX (doxycycline hyclate)* *doxycycline hyclate DR* *doxycycline monohydrate* *minocycline ER* *minocycline tablets* *MORGIDOX (doxycycline)* *ORACEA (doxycycline)* *SOLODYN (minocycline)* *VIBRAMYCIN Suspension, Syrup (doxycycline)*	▪ Non-preferred agents will be approved only after documented failure of a preferred agent ▪ An age override is required for patients less than 8 yrs of age

TOBACCO CESSATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bupropion SR 150 MG nicotine gum OTC buccal (nicotine polacrilex) nicotine lozenge OTC buccal (nicotine polacrilex) nicotine patch OTC (nicotine)	*CHANTIX (varenicline)*[CL] *NICOTROL inhalation (nicotine)* *NICOTROL NS nasal (nicotine)*	▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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ULCERATIVE COLITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
APRISO (mesalamine) PENTASA (mesalamine) sulfasalazine	ASACOL HD (mesalamine) *balsalazide* *DELZICOL (mesalamine)* *DIPENTUM (olsalazine)* *GIAZO (balsalazide)* *LIALDA (mesalamine)* *UCERIS (budesonide)*	▪ Link to PA Form for Ulcerative Colitis Drugs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent
Rectal		
CANASA (mesalamine) mesalamine	*SFROWASA (mesalamine)*	▪ Link to PA Form for Ulcerative Colitis Drugs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate tablets isosorbide mononitrate tablets isosorbide mononitrate SR tablets NITRO-BID (nitroglycerin) ointment nitroglycerin ER oral capsules nitroglycerin transdermal patch NITROLINGUAL spray (nitroglycerin lingual spray) NITROSTAT (nitroglycerin sublingual tablets)	*isosorbide dinitrate sublingual tablets* *isosorbide dinitrate ER tablets, capsules* *NITRO-DUR (nitroglycerin transdermal patch)* *nitroglycerin translingual spray* *NITROMIST (nitroglycerin translingual spray)*	▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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